

Montana State Prison Mental Health Discharge Planning

Case Studies

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What Would Help?

Offender A Case Study: Revolving Door

Offender A could be considered a case of the “revolving door” phenomenon that is a growing concern with mentally ill offenders in the prison systems. The revolving door phenomenon refers to individuals with psychiatric disorders having multiple episodes of repeat arrests and incarcerations.

Offender A is a 43 year old male who is currently incarcerated at Montana State Prison. His current offenses include criminal endangerment and criminal mischief, which he committed in 2001, and was sentenced to twenty years, with seven suspended, between the two crimes. Offender A has been incarcerated at MSP and released to community parole four times in approximately twelve years. He was first admitted to MSP in 2001 shortly after his sentencing and remained incarcerated until 2004. At that time, he was released for the first time on a parole status to community probation and parole. Offender A made his way back to MSP in 2007 but for a shorter period of time of incarceration amounting to just over one year. In 2008, he again returned to the community on a parole status. During this time on parole, Offender A absconded from parole, was later located in a different state, and taken back into custody, being placed at START revocation initially but transferring to MSP a short three days later. In 2010, Offender A was again paroled and released to the supervision of community probation and parole. He again returned to MSP in 2012 but was released back to the community within two to three months. Offender A came back for his most recent incarceration in April 2013. Offender A once again has received a parole but has yet to be released. The “door” continues to open and shut but never latches completely.

What was failed to be mentioned above is that Offender A is diagnosed with paranoid schizophrenia. Offender A has not committed any new crimes that have resulted in him being incarcerated multiple times. Each time he has come back because of a drinking violation or need for “mental” stabilization. Every time Offender A has been released to the community, it has been to a mental health residential placement called adult foster care that is coordinated with the community mental health center. Offender A has almost continuously been on an antipsychotic medication, most consistently an injection of Risperdal to help alleviate symptoms of his illness. There have been noted times in the past, during community supervision, that he had not been medication compliant. During those times of non-compliance, Offender A often suffered from increased symptoms of schizophrenia, most consistently reports of one fixed delusion. This delusion regularly rears its ugly head to divulge a key symptom that indicates a need to assess the status and needs of this offender. Offender A continuously identifies himself with a different last name and also being a representative of the state government often explaining that he has “diplomatic immunity.” He requests finger print checks to confirm this. He also at one time in the past explained that he must go to Washington DC in order to complete his investigation. This specific delusion has been continuously documented in correctional notes since 2009.

What also has been documented consistently in correctional notes is the incredible amount of resources this offender has received from the community and prison institution. He has continuously been monitored by prison staff while incarcerated receiving mental health care to include medication, mental health treatment unit, and discharge planning. Residential services have been coordinated with the community mental health center every time he has been released. He has always been approved for SSI and Medicaid when he is released providing the appropriate funding for his needs. The community probation and parole office has always designated him to the mental health caseload which includes an officer that is more sensitive to the needs of an offender with a serious mental illness. Documentation has provided a significant awareness of when this offender is doing well compared to times of de-compensation. During episodes of increased symptomology, it appears that steps were taken to stabilize this individual or to increase his level of care.

Unfortunately, Offender A continues to shuffle between the community and institution. A variety of resources have been used to help this offender with his serious mental illness over the years. Due to the nature of the illness and often the lack of insight the offender has for the importance of medication compliance, this could be an ongoing battle for all parties for years to come. It will take a team approach between all the parties to work with him consistently to help educate on the illness, encourage treatment compliance, and maintain stability in the community. The hope is to be able to monitor and supervise him in the community where he can best be treated for his illness in a group home setting. Offender A has been approved for a group home placement and is currently on a waiting list. When a bed becomes available, he will again move into the community and hopefully will stay there for the remainder of his supervision time.

Offender B Case Study: Barriers

This is a case about barriers. What kind of barriers you ask? The barriers that label an offender, that make community service providers leery, and that make a release into the community tricky.

Offender B is a 34 year old offender, currently on community supervision with the local probation and parole office. He discharged his prison sentence on March 31st, 2013. Where did he discharge to? A homeless shelter. You see, Offender B is a sex offender; his current crime is sexual intercourse without consent. He has also been diagnosed with paranoid schizophrenia and was on an injectable antipsychotic medication at the time of his release. He had been through this cycle during a previous discharge and was anxious about this being his situation again. The community that he was going to was changed literally within days due to being denied by the original location's probation and parole office.

It's not a mystery that most offenders have some barriers to success. Most will have conflicts with being labeled a "felon", registering as violent and sexual offenders, seeking employment, establishing residence, having limited social supports, participating in treatment, and following conditions of probation and/or parole. Offender B has a combination of barriers that make his case difficult. The first is his mental illness. He has been diagnosed with a severe and disabling mental illness and has limited insight into the treatment needs of his illness. He does not always feel he needs medications to treat his symptoms and at times questions the importance of remaining on them. This poses concern because of the de-compensation that will potentially occur. Offender B experiences symptoms of schizophrenia even while being treated with medications. Most recent documentation indicates that he has reported auditory hallucinations and has also requested internet for the purpose of researching such things as "demonology and spirits that can manipulate emotions." The second barrier that causes concern is the sex offender status. Offender B is required to participate in sex offender treatment and register his address at all times; he is currently designated as a tier level two sex offender. He is restricted from many areas, such as close proximities to school or daycares, and he also has to have relationships with females approved by his treatment provider and probation officer. A third component at the time of release was homelessness. There were no mental health residential homes willing to take on a sex offender for risk of the safety of the other clients. Offender B also had no financial resources at the time of release in order to secure an independent residence. There seemed to be no other initial option than to go to the rescue mission.

Offender B did not have any options for residence, had no initial income, was expected to remain on his medications, was expected to report to the probation officer, and was expected to participate and pay for continued sex offender treatment. These are always conditions and requirements that a lot of offenders must follow, but with a mental illness such as schizophrenia,

there can be some additional challenges for success in the community. One of those challenges is identifying the need for treatment and accessing it. Offender B is currently receiving mental health treatment in the community and receiving monthly injections to treat his illness. The probation officer is aware of moments when he is experiencing symptoms of his illness and assures that he is still treatment compliant. He also receives payee services from St. Vincent DePaul to help with money management. He receives monthly checks from SSI and qualifies for Medicaid to aid the costs of mental health treatment and medication. He also participates in sex offender treatment weekly and the treatment provider and probation officer work closely to assure he is compliant with all regulations in that area, such as appropriate contacts. Another challenge that presents for sex offender treatment is working with an individual that has a thought disorder. These individuals don't always learn the same way that others do or they may struggle due to increased symptomology of the illness. This can be frustrating for the individual and treatment provider.

These are a few examples of the challenging barriers Offender B possesses. Community mental health has limiting factors of services due to the sex offender status. The sex offender treatment providers become concerned with symptoms of the mental illness. The combination of these two factors places him with a special offender probation officer. The complexity of the case and barriers therein requires additional attention and consideration by all parties. It's of great importance that all the needs of this offender are taken into consideration to help him succeed in the community.

Offender C Case Study: Successful Reentry

Offender C was an inmate for the second time at Montana State Prison from October 2009-June 2011. During that time he was housed on the mental health treatment unit and was treated for schizophrenia. Offender C was always treatment compliant while incarcerated, continuously participating in groups and activities in a positive manner. He even became like a group mentor at one point for the rest of the inmates on the block. He acknowledged his mental illness and the need for help; his insight into the illness and ability to take ownership for his thinking and behaviors was a positive change from the variety of other clients that would consistently challenge it.

It was no surprise when Offender C was granted a parole with an appropriate mental health plan in June 2010. His release plan consisted of residing in an adult foster care residence through the community mental health center. A few steps that needed to be taken care of consisted of applying for adult foster care, getting accepted as a resident, waiting for an available bed, and applying for Supplemental Security Income. Offenders can apply for SSI if they have been granted a parole or are 120 days from a discharge. Typically an SSI case will take an estimated 3-5 months for a decision to be made. In this offender's case, he was able to apply for SSI and receive a phone interview to get the process started. In order for him to go to adult foster care, he would need that funding. Offender C waited approximately 6 months before receiving approval for SSI. Once funding was approved, then placement options could be reviewed. An adult foster care provider finally accepted him in May 2011 and he was released in June 2011, one year after he received a parole. Offender C had to wait an extended time for parole, but he was exceptionally patient with the whole process.

With funding and placement established, Offender C was prepared for the best possible release plan that would be supportive of his mental health needs. He was appropriately monitored by community corrections, participated in proper treatment including remaining medication compliant, and also was able to hold employment through the mental health center. Offender C never violated while on parole and discharged his sentence completely in May 2012. Thus far, this appears to be a case of success, where resources were utilized and the offender was given an opportunity to overcome a criminal history and work on maintenance and stabilization of mental illness.

Offender D Case Study: When Addiction is Prescribed

Offender D is a 54 year old male who is currently on parole in the community and serving a sentence for criminal distribution of dangerous drugs, burglary, assault, and theft. Offender D came to Montana State Prison in May 2013 from St. James hospital after being treated in ICU for loss of consciousness, respiratory failure, kidney failure, and the amount of narcotics in his system. It was concluded that the offender had been using morphine which was not prescribed to him at that time; hospital staff did not believe this to be a purposeful overdose. He was evaluated by the prison psychiatrist upon arrival to MSP due to his condition and the extensive amount of medications he was prescribed in the community. At that time he denied any suicidal ideation, had no evidence of psychosis, and did not present with any delusions, hallucinations, blocking, derailment, confusion, or disorganization. The doctor noted that there was probable substance dependence to include opiates and potentially other drugs. The offender had appeared to clear up significantly after a few days without the influence of drugs.

Correctional documentation suggests a long history of Offender D's struggles with chronic pain and other health issues. The purpose here is not to disregard the offender's struggles but rather shed light on a pattern of drug abuse and dependency that has continued for years. History shows that Offender D has accessed many services related to his chronic pain including continuous doctor appointments with a variety of providers which almost always resulted in being prescribed medications. Offender D had significant complications due to the overdose on narcotics such as renal failure, respiratory failure, and hallucinations; however, the seriousness of this incident did not stop him from accessing another provider and being prescribed opiate medications just days after his release back into the community in June 2013. Concern was high enough that the pharmacy had made contact with the community probation officer regarding a script the offender had brought in for a large amount of opiates. Unfortunately, there is nothing in his parole conditions that would be able to stop him from obtaining these medications. A few weeks after this, the offender brought in a list of medications that he was going to ask another doctor about. At this time he was warned, by the probation officer, of the risks of overmedicating and the issues he's had in the past. The offender still was prescribed more pain medications. Approximately a month later, there were reports of him being sick and in the hospital but no reasons stated.

Offender D has had a continued pattern of overuse of prescription medications. He continues to jump around to different doctors to obtain the desired medications and successfully attains them. Often these medications are overlooked in parole conditions because they are prescribed and legal, but the offender's history suggests overuse and abuse that could be easily defined as dependency. How does one receive appropriate treatment for medical needs without complicating the pattern of addiction? No one can deny the right to receive appropriate medical treatment, but how appropriate is treatment that encourages and helps the behaviors of an addict and how long will this pattern continue?

Potential Barriers to Success

Mental Illness

Medications

Income/Funding

Residential/Housing

Crime/Felony Record

Violent/Sexual Registry

Limited or No Social Supports

Limited Community Support

What would help?

- Transitional living in community for sex offenders
- Larger group home availability for offenders
- Possible group home on MSP grounds for a slower transition (similar to MSH)
- More pre-release options, especially for those with special needs
- Funding to assist with the initial re-integration into the community before SSI/SSDI kicks in, to fill the gap. There is always a gap between when people will actually start receiving funding, typically 30 days or sometimes longer.
- 90 days' worth of meds upon release (due to the wait that they will often endure before seeing a provider in the community) (also so that funding has time to kick in)
- Being able to apply for Medicaid prior to release
- Special funding for those going into a group home but don't have Medicaid or other funding yet. The majority of group homes are only taking Medicaid patients for residency, which presents a challenge because inmates can't actually apply until they're released into the community and the group homes aren't likely to take them unless they have it secured.
- Expanded mental health probation officers in the community

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